**Attachment A**

## IDAHO MEDICAID DME/SUPPLIES REQUEST FORM

**State of Idaho**
**Department of Health & Welfare**
**Division of Medicaid**
**PO Box 83720**
**Boise, ID 83720-0036**
**(866) 205-7403**

**URGENT**
**YES NO**
**If urgent state reason_____**
**_____**

**MEDICAID DEPARTMENTAL USE ONLY**

**Provider Name:**

**Contact Person:** **Provider Number:** **Phone No.:** **Fax No.:**

**Provider's Address:** **City:** **State:** **Zip:**

**Participant's Name:** **Client MID:** **Participant's DOB:**

**Participant's Address:** **City:** **State:** **Zip:**

**Physician Name and Address:**

**Insurance Information:**

**Diagnosis:** **Healthy Connections:** **Yes** **No** **HC Referral No.:**

| DESCRIPTION | HCPC Code | QUANTITY | START DATE | STOP DATE | PRICE | Rental/Purchase |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Please attach all appropriate medical necessity and pricing documentation to support the request**

**FAX: (800) 352-6044**